

Quality Data Model (QDM) User Group Meeting | AGENDA/MEETING MINUTES

Meeting date | 11/19/2014 2:30 PM EDT | Meeting location | Webinar video link: <https://www4.gotomeeting.com/register/303510935>

Attendees: Itara Barnes, Cynthia Barton, Howard Bregman, Zahid Butt, Elena Campos, John Carroll, Lynn Cason, Anne Coultas, Floyd Eisenberg, Trish Elder, Pavla Frazier, Michelle Hinterberg, Yanyan Hu, Rosemary Kennedy, Joseph Kunisch, Tammy LaFavcr, Rute Martins, Rob McClure, Christopher Moesel, David Nilasena, Vaspaan Patel, Susmita Petkar, Bill Presley, Kala Ramesh, Stan Rankins, Tom Ricciardi, KP Sethi, Hetal Shah, Anne Smith, Dawn Stapleton, Lindsey Wisham, Jeffrey clyman, jane Koenig, Balu Balasubramanyam

Agenda Item	Time/Presenter	Objective	Discussion/Options/Decisions
Participants	2:30 / Balu	Welcome participants	
Oct 15th Meeting Minute Review	2:30 / Chris	Review discussion, decisions, and action items from previous meeting	Summarized last User Group Meeting conversation.
QDM Issue Review	2:35 PM	<u>QDM-37</u> : Fundamental problem with diagnosis datatypes. ...continued from last UG discussion	<p>MITRE described all the concerns related to Diagnosis, <i>Active</i>, <i>Inactive</i> and <i>Resolved</i> datatypes. MITRE proposed using <i>Condition</i> as a datatype, with new <i>assertion datetime</i> attribute. MITRE questioned the usefulness of <i>ordinality</i> to indicate a principal diagnosis, since there is not a formal link between the <i>Diagnosis</i> datatypes and <i>Encounter</i> datatypes. An approach to consider for the future might be creating a <i>principalDiagnosis</i> attribute on <i>Encounter</i> instead. MITRE also asked if laterality and <i>conditionStatus</i> are needed. In addition, MITRE proposed removing <i>patient preference</i> and <i>provider preference</i>, <i>start</i> and <i>stop</i> date time. The proposed changes were then compared to the QUICK and FHIR <i>Condition</i> datatypes (as on the JIRA QDM-37 ticket).</p> <p>One of the UG members confirmed that <i>assertion datetime</i> might be helpful, but it does not solve the <i>ordinality</i> issue associated with <i>principalDiagnosis</i>. In some cases, the diagnosis may have even happened <i>before</i> the encounter. MITRE stated that QUICK and FHIR support a hierarchical model while QDM is very <i>flat</i> in being able to represent hierarchical relationships. For example, QUICK has a way to associate an Encounter to a Condition with a role (such as <i>principalDiagnosis</i>). The UG member wanted to find out more about how EHR vendors would represent it. He also stated</p>

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			<p>that the <i>laterality</i> attribute may be necessary, since SNOMED does not generally support pre-coordinated concepts.</p> <p>Another UG member agreed with the primary member's comments. He stated that the issue of <i>principal</i> is usually in the case of an <i>inpatient</i> encounter and so, very specific. Most process measures are Encounter-based, so in many cases, tracking <i>ordinality</i> on the Condition does not make sense. He further stated that we needed to take the Encounter perspective and address it from that dimension, and that the <i>Condition</i> needs to be attached to the Encounter. The same UG member suggested that <i>conditionStatus</i> might be useful for determining if a Condition is <i>inactive</i>.</p> <p>MITRE stated that there is concern with having <i>conditionStatus</i> as its own attribute, since EHRs might only store the <i>most current value</i> for that attribute. As a result, a Condition could have a <i>conditionStatus</i> value of <i>resolved</i> even though it was not yet resolved in the Encounter of interest for the measure.</p> <p>Another participant stated that FHIR <i>status</i> and QDM <i>status</i> are very different. In FHIR, the status represents the <i>status</i> of the actual assertion. However, QUICK supports both the <i>conditionStatus</i> and <i>status</i>. A participant stated that FHIR might expect the status to be reflected in the code– e.g., cancer in remission, as a pre-coordinated code as opposed to an attribute reflecting the condition's active/inactive/resolved status. The group went on to further discuss <i>other relevant fields</i> in QUICK/FHIR. There was a question on whether the <i>category</i> listed in the examples in the PPT presentation included <i>Condition</i>. MITRE stated that in FHIR, it considered them all to be <i>conditions</i>.</p> <p>The participants stated that <i>complaints</i> and <i>conditions</i> are entirely different. A <i>complaint</i> is something the patient reports, while a <i>condition</i> is a finding that the doctor observes. FHIR clumps them together, which can be confusing from a clinical standpoint. There were also questions about whether value sets reference the above ambiguities and if that may resolve these issues. Another participant suggested that we needed to understand best practices to handle problem lists. It is not going to help just asking a few providers, but we need an iterative process. It is not a QDM issue per-se, but an EHR implementation issue.</p>

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			<p>On the topic of the <i>Symptom</i> datatypes potentially being considered for retirement, one of the members asked what would be the equivalent representation of a <i>Symptom</i>? Another member chimed in and stated that the way it is defined in FHIR is not appropriate. A <i>condition</i> is not a <i>symptom</i>.</p> <p>In regard to FHIR definitions for the components of the <i>Condition</i> resource, one of the participants read them out for the benefit of the participants.</p> <p>One of the participants stated that categorizing a general condition called <i>Condition</i> is more useful than trying to break them up into different categories such as <i>Complaint</i>, <i>Symptom</i>, <i>Finding</i>, etc. Another UG member stated that if QDM aligns with FHIR's <i>Condition</i> resource, there needs to be "full" alignment across all these data types rather than one or two categories.</p> <p>A UG member then suggested that current eQMs assume that all diagnoses are <i>confirmed</i> diagnoses, and changing those fundamental definitions may introduce more noise and errors. Another UG member stated that the <i>principal ordinality</i> makes some cases clear, but that in other cases, EHRs may not make such a strong distinction between <i>confirmed</i> and <i>unconfirmed</i> diagnoses.</p>
	3:05 PM	QDM-99: Intent of Diagnosis Datatypes Start Datetime ...related to QDM-37	<p>MITRE presented the problem and suggested an <i>assertion datetime</i> attribute as a potential way to allow authors to reference when a diagnosis was asserted (as opposed to the onset datetime). Current measures that say a Diagnosis <i>started during</i> an encounter probably did not intend to mean that the diagnosis onset started during the encounter. One of the participant stated that it does not fully solve all the problems (especially as it relates to principal diagnoses). This participant suggested that the answer to the question in JIRA is not <i>assertion</i>, but rather that the principal ordinality has to be solved.</p> <p>MITRE explained that the solution for QDM-99 was not intended to solve the principal ordinality issue, but to discover and solve the discrepancy between the <i>intent</i> and implementation of measures that say a diagnosis "started during" an encounter. The participant then asked how this is intended to handle <i>multiple</i></p>

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			<p><i>assertions</i>. MITRE indicated that its suggested intent was that <i>assertion datetime</i> reflected the <i>first time</i> the doctor asserted the diagnosis (in alignment with the FHIR definition of the same attribute).</p> <p>A question was raised regarding if measures are really interested in <i>new</i> diagnoses or if they actually want to ensure that the condition was <i>re-asserted</i> as active. Some UG members had assumed that <i>assertion datetime</i> reflected a recurring assertion, made at every encounter. One UG member asked if <i>author time</i> was really the correct HL7 field to reflect <i>assertion datetime</i>. Another member suggested there are at least three interesting questions: (1) When did the condition start? (2) When was it <i>first</i> diagnosed? (3) When has it been confirmed as active?</p> <p>MITRE requested feedback from measure authors who have used the <i>Diagnosis started during Encounter</i> phrasing: what was your intent? This information is needed in order to provide a proper solution.</p>
	4:05	<u>QDM-87</u> : Ability to refer to immunizations is inconsistent with interoperability standards	Was not discussed due to a lack of time.
	4:30	Conclusion	Next QDM User Group meeting will be held December 17th from 2:30-4:30PM EST.
Next steps			Continue to get clarity on Diagnosis data types and linkages to Encounters.